
Peer Discussions of Cancer Among Hispanic Migrant Farm Workers

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Synopsis

Hispanic migrant agricultural workers' exposure to pesticides and other agrichemicals places them at increased risk for a variety of acute and chronic conditions, including cancer. As a socioeconomically disadvantaged group, migrant workers also face many barriers to effective cancer control. In 1992, a series of focus groups was held with 55 Hispanic migrant agricultural workers (22 women, 33 men) in central Wisconsin to gather information on their

knowledge and attitudes regarding cancer etiology and treatment, their practices regarding cancer screening and early detection, and their concerns regarding occupational exposure to pesticides.

Beliefs that pesticides are toxic and can cause health problems were common among participants. In addition, however, participants reported that they are reluctant to demand occupational protections to which they are entitled because they are afraid of losing their jobs. Study results also suggest that barriers to effective primary and secondary prevention of cancer in this Hispanic migrant agricultural worker population include knowledge and information barriers, cultural barriers, and socioeconomic barriers.

A lack of knowledge and information regarding the causes of cancer, its prevention, and its early detection and treatment was evident among participants, which in turn was reflected in strong fatalistic attitudes toward the disease. Cultural barriers included attitudes of embarrassment and shame associated with physical examinations and women's strong discomfort with male clinicians. Socioeconomic barriers to secondary prevention included the cost of obtaining health services, time constraints associated with the need to work and long working days, and a lack of transportation. Efforts to improve cancer screening as well as other preventive health services in the Hispanic migrant agricultural worker population must acknowledge these barriers and address as many of them as possible to be successful.

MIGRANT AGRICULTURAL WORKERS in the United States face many hardships, including physically demanding labor, crowded and substandard housing conditions, and chronic poverty (1,2). Although information on the health status of migrant agricultural workers is fragmentary and limited by methodological difficulties associated with studying a transient population, there is evidence that migrants and their families disproportionately suffer from a variety of acute problems such as intestinal parasites, dermatitis, respiratory conditions, and pregnancy complications, and from chronic conditions like hypertension, diabetes, and physical disabilities) (3–

7). Migrant agricultural workers' repeated and lengthy exposure to pesticides and other agrichemicals is of particular public health concern. Such exposure can lead to pesticide poisoning and other acute problems, and it is suspected to increase the risk of birth defects and a variety of cancers (7–9).

Cancer incidence and mortality data specific to the migrant agricultural worker population are not available. In general, however, socioeconomically disadvantaged groups have been found to have the lowest relative survival rates for nearly all types of cancer (10–12). A substantial portion (at least half) of socioeconomic differentials in cancer mortality is

believed to be the result of delays in diagnosis and inappropriate care-seeking (12). People with socioeconomic hardships often are more concerned about day-to-day survival than seeking care for minimal, vague symptoms or for preventive health services such as disease screening. People with socioeconomic hardships also experience a variety of difficulties in obtaining health care services, with problems related to cost and access paramount among them. These structural barriers make the single most important factor in cancer control—early diagnosis—difficult to achieve. In addition, barriers related to knowledge and attitudes have also been associated with delays in diagnosis and treatment, suggesting that misinformation and misperceptions regarding cancer are related to delays in seeking care for symptoms and receiving therapeutic intervention (13,14).

The Wisconsin Farmers' Cancer Control Program (WFCCP) is a program of the Marshfield Medical Research and Education Foundation and is funded by the National Institute for Occupational Safety and Health of the Public Health Service (15). Through WFCCP, researchers attempt to identify and reduce barriers to cancer control among farmers and their families. Several projects associated with WFCCP involve cancer-related research and service provision in the Wisconsin migrant agricultural worker population.

WFCCP staff conducted a survey interview project in which migrant agricultural workers' knowledge, attitudes, and practices related to cancer were investigated. As a prelude to this empirical study, preliminary data were gathered in focus group interviews with migrant agricultural workers in Wisconsin. The purpose of this qualitative study was not to compare migrant workers' beliefs, attitudes, and screening practices with those of other groups or with the general population. Rather, the purpose was to collect background information and to achieve a better understanding of migrant workers' knowledge and beliefs about the causes of cancer, their attitudes in regard to cancer detection, treatment and cure, and their concerns regarding their occupational exposure to pesticides. The results are being used to inform and guide cancer control research and screening interventions for migrant agricultural workers in Wisconsin. Additionally, the results can be informative for health professionals planning preventive health services projects in other migrant communities.

Methods

Approximately 8,000 agricultural workers and family members, the majority of whom are Mexican

Americans from the Rio Grande valley of Texas, migrate to Wisconsin each summer primarily to pick cucumbers, peppers and other vegetables; to trim, paint, and harvest Christmas trees; and to work in vegetable canneries (16). As a group, Wisconsin migrant agricultural workers are socioeconomically disadvantaged, with low family incomes and limited educational attainment (17).

Eight focus group interview sessions (four with men and four with women) were held between July 9 and August 2, 1992, with adults who migrated to Wisconsin for seasonal agricultural work. The group sessions were held in a variety of locations in central Wisconsin, including a migrant health center and a Catholic church. A set of open-ended questions was developed for use in all of the groups, with minor differences in the questions for men and women related to cancer screening issues.

In general, participants were asked to discuss their knowledge, beliefs, and experiences regarding cancer, its causes, and its treatment. Participants were invited to share stories of people they have known with cancer and were specifically asked how the cancer was treated and the outcome for the patient. Participants were also asked about their prior use of and concerns about specific cancer screening tests, such as mammograms and Papanicolaou (Pap) tests for women and digital rectal examinations for men. In addition, participants were asked several questions about their exposure to agricultural chemicals and pesticides and related health concerns. Questions were developed by WFCCP staff members, with assistance in phrasing and translation from staff members at the National Migrant Resource Program and the Migrant Clinician's Network.

Standard focus group interviewing techniques were used (18). Each focus group was facilitated by a trained moderator and an assistant; both were Hispanic and bilingual. The moderator for the female groups was raised in a migrant family and was a medical student at the time of the group discussions. The moderator for the male groups is a former migrant worker who runs a small business in central Wisconsin. The moderators did not express their own opinions, experiences, or knowledge during the groups. Moderators were trained to facilitate the groups by asking the questions, probing for more in-depth responses, and intervening if the discussion got off track or was being dominated by one person.

Participants were individually recruited by a husband and wife team of former migrants who are currently active in health advocacy and church-related activities within the migrant community. Recruiting took place at several migrant housing camps in

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central Wisconsin and resulted in 8–12 persons signing up to participate in each of 8 focus groups. The groups were held on Sunday afternoons and evenings (times when workers typically are not in the fields or factories). Participants were paid a cash honorarium. The discussions were conducted in Spanish and were audio-recorded for accuracy. At the conclusion of each focus group discussion, participants were given Spanish-language pamphlets on cancer symptoms and screening tests, and they were given the opportunity to ask questions and discuss concerns. The audiotapes were subsequently translated and transcribed. Content analysis techniques were used to analyze the English transcripts.

Results

A total of 55 people (22 women and 33 men) participated in 7 focus group discussions, each of which lasted approximately 90 minutes. The results of one female focus group were not included in this analysis, since only two women attended, and they could not have a direct discussion because one preferred to speak English while the other preferred Spanish. Six of the seven groups were held during the same week, and there was no evidence that participants in the early groups had informed those in the later groups about the questions or the experience in general. Group size in the other sessions ranged from 3 to 12, with an average of 8 participants. The participants ranged in age from 18 to 63 years and were involved in a variety of employment situations, including Christmas tree care, vegetable picking, and cannery work.

Beliefs about cancer etiology. Participants discussed a wide variety of beliefs regarding the causes of cancer, including such things as alcohol, poor diet, sun exposure, and birth control pills. To the question “What are some things that can cause cancer?” smoking was a reply in all groups. Along with

smoking, the most common cause of cancer mentioned was injury. Cuts, blows, bruises, and a variety of other injuries were offered as the cause of many different kinds of cancer. The myth that an injury can lead to cancer was accepted and promoted by several participants in all of the groups, and in no case did another participant question or challenge the assertion.

Some examples

I had a cousin who had her uterus and her ovaries removed when she was still a young, single girl. And the reason they gave her was because she worked hard and she fell while working in the fields and one of her ovaries became infected (with cancer).

In my family, it started with my grandmother. She first got bone cancer. I think it started from a bump on the head from a car door. First her scalp got little balls on it. Then her eyes got the little balls on them and this made them bulge out like a frog. It was a very bad illness.

Another common misperception was that the neglect of an illness or a health problem can lead to cancer. As a male participant said “Whatever illness that you don’t care for can become cancer.” Several focus group participants (both male and female) stated their belief that untreated vaginal infections and sexually transmitted diseases can lead to cancer. One female participant warned, “If we don’t douche after sexual relations we can get uterine cancer.”

Other comments suggested that several participants confused cancer with other conditions that can progress from one body part to another (infections, for example) or with diseases that involve vascular complications leading to amputation, such as diabetes.

Examples

I knew a woman in the town I’m from, who was sewing her clothes, and she pricked herself with a needle, right here on the tip of her finger. It got infected. So to cure herself she went to, you know, people who know about medicine. And it was still infected. So she went to the doctor and they had to cut off her finger. Then when she was still going to the doctor, it spread and they cut off her whole arm, then it spread to her legs and they cut off her legs, so she was left only with, you know, the part of her body without arms and legs ... She suffered from cancer about one year, I think. She died.

We were playing basketball and (my friend) took off his shoes. Then a week or two later, he said that he started to get an itch between his big toe and his other toe. He started to scratch it and scratch it more ... then it turned into a sore, and this friend of his gave him a remedy "Mexican style"—he put battery acid on it to see if it would. Well it burned pretty good ... So then his daughter took him to the doctor, and they told him he had cancer in his foot. They had to operate on his foot. But I don't know what it was, what kind of cancer it could be. I just heard that it was cancer.

I know a guy who had to have his legs amputated below the knees. It was a cancer of the body. It began like a wound; the wound got infected.

Agricultural chemicals were mentioned by a small number of participants as possible causes of cancer. Two people expressed concern that eating fruits or vegetables from the field before washing them could cause cancer. In addition, one woman stated that "pesticides cause skin cancer because they are in contact with the skin."

Attitudes toward cancer: fear and fatalism. An intense fear of cancer was pervasive among all focus group participants. Strong fears were associated with many aspects of the disease, including death, pain, and the destruction or mutilation of a patient's body. In every group, several people expressed fear over the suffering and pain that cancer victims must endure—pain that was consistently described as "burning" or "like fire."

Participants' fears regarding cancer were coupled with a strong sense of fatalism or *fatalismo* (that is, there is little or nothing a person can do to prevent or survive cancer). The stories participants (both male and female) shared about people they have known with cancer powerfully conveyed this fatalistic attitude. Nearly every story told about a neighbor, friend, or relative with cancer involved great suffering that culminated in death. *Fatalismo* was also expressed in the common belief that whether or not a person gets cancer or is cured is God's will. Strong religious faith was often coupled with a sense of personal powerlessness.

For example

I have a lot of fear of that (cancer), but, well, God will take care of us. We may come out ahead and be spared from cancer.

What worries me the most is, well, with cancer, many times it's not curable ... I'm a very decisive person and I would hope. But only God can decide that if one day I ever get cancer that He would take me away as quickly as possible.

Only God would be able to detect stuff like that in our bodies.

Participants did share some stories of people they knew who were able to survive or "beat" cancer. Survival, however, was often portrayed (by both men and women) as a miracle or a matter of faith, rather than the result of successful treatment or early detection. One woman stated, "It's because she has a lot of faith that she is cured. And she's always giving God thanks. I think that that's one of the things; faith is everything."

Fearful and fatalistic attitudes towards cancer may stem in part from a lack of knowledge about cancer treatment. Both men and women shared stories in which cancer treatment was the cause of severe pain, disfigurement, and multiple amputations. The terms "radiation" and "chemotherapy" were mentioned by only one participant in the study; and the vast majority of surgeries mentioned involved limbs (rather than tumors or body organs) being removed. Examples of misinformation regarding cancer treatment include the following:

I knew a lady who had leukemia. They began by cutting off her hair. Then later, they had to cut out pieces of the cancer in her extremities, her feet, her arms, also in her legs.

I read many magazines that have studies that are being done on medicines to control cancer because right now there are no medications to control cancer. Let's say you get cancer and the cancer will continue to grow and grow, there's no stopping it ... with cancer they have not been able to find a medication that will control it.

Barriers to early detection. Information about a number of barriers to the widespread use of cancer screening services emerged from the focus group discussions, and generally were of three types—(a) a lack of knowledge and education regarding cancer, (b) personal-cultural discomforts with medical examinations, and (c) socioeconomic barriers.

Lack of cancer knowledge. Many participants' comments suggested that they generally perceived

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cancer as a disease that progresses and spreads. In addition, participants in both the male and female groups stated that health professionals could help them detect cancer "before it is too late." Thus, participants showed a general understanding that cancer symptoms deserve immediate medical attention. Several participants, however, also expressed great concern over not being able to recognize symptoms or signs of cancer. As one woman stated, "The thing that worries me most is that we don't have enough knowledge to detect the symptoms of the illness. And because of that, when we go to the doctor it is too late."

Specific knowledge about tests and procedures used for the early detection of cancer was also lacking. In the male focus groups, a large picture of male internal organs highlighting the prostate gland was shown and digital rectal examinations were explained as a way for physicians to detect rectal and prostate cancers. The majority of the male participants had not heard of the prostate gland or of prostate cancer, and many (especially the younger men) stated that they had not heard of the digital rectal examination before. Only two older men admitted to having a digital rectal examination in the past.

In the women's groups, the moderator used a plastic model of the female reproductive system and a speculum to demonstrate the Pap smear procedure. In addition, participants were shown a drawing of a woman getting a mammogram. In response to the moderator's questions, most women appeared to know that these are important tests, although the understanding of the specific purposes of the tests was quite superficial. For example, all female participants had heard of and most had received at least one prior Pap test. The prevailing perception, however, was that Pap tests were used with sexually active women to detect a variety of genital problems, primarily vaginal infections and sexually transmitted diseases. In addition, while it appeared that most women had heard of mammograms, several women stated that mammograms were used to "prevent"

cancer, and there was a general lack of knowledge about age-specific guidelines for screening.

Personal or cultural barriers. While a lack of appropriate and accurate information appeared to be a significant barrier to screening, participants also discussed a number of other reasons why it is difficult for them to go to a health care provider to report symptoms or to receive screening tests. Feelings of *vergüenza* or shame, embarrassment, and discomfort—related to both health care providers in general and certain cancer screening tests in particular—emerged as particularly salient barriers to early detection. In addition, female participants strongly voiced their discomfort with male clinicians performing Pap tests. Many participants stated that they would be less embarrassed by the procedure and less afraid to ask questions with a female provider.

Some women stated that they generally did not feel uncomfortable or embarrassed about receiving medical tests or examinations, but that they did have a strong tendency to put off seeking care until symptoms worsen or an illness becomes serious. As one woman stated, "It's just laziness. It's the laziness that many people have because, since you don't feel bad, you put it off." Similarly, many male participants also spoke of their reluctance to seek medical care unless "things get really bad." A man explained

I've got something wrong with my kidneys, but I haven't gone to the doctor yet. When I'm not working, it doesn't hurt. And when it hurts, I'm working. I'm not going to get it checked if it doesn't hurt (when I'm home)."

Male participants also expressed a general discomfort or embarrassment with medical examinations, although few offered specific reasons for this attitude. Cultural attitudes towards masculinity (*machismo*) may be playing a role. One man said, "I trust them (doctors). But as men, we're really macho and we don't go ... it's embarrassing. You don't want people to say that you're weak, you're a woman."

All men were asked the question, "Would you get a digital rectal examination if it were offered free at (the migrant health clinic)?" Nonverbal communication (as documented by the assistant moderator) suggested that the digital rectal examination in particular made several men uncomfortable. Some of the older men stated that, although it would be very unpleasant, they would have this type of examination because it might help them live longer. It should be noted that most men were silent when this question was asked until they were called upon by the

moderator. When asked to comment, the majority of the men were quite reluctant about the test and responded with the following types of statements:

It is embarrassing. (Why?) Because you're a man, and you don't want someone looking at you there.

They can't check you with machines? Like with X-rays or anything?

I'll have to find a doctor with a small finger!

Socioeconomic barriers. Female participants raised several important issues and concerns they have regarding their access to Pap tests and mammograms. The most common socioeconomic barriers mentioned by women were cost, a lack of transportation, and a lack of time to attend to their own health needs. Many women mentioned that they cannot afford health care in Texas and that they try to take advantage of the services offered by the migrant health center in central Wisconsin while they are working in the area.

Male participants raised some similar concerns about the cost of medical procedures. In addition, a common point raised in all of the groups was the difficulty in getting medical care (even at a clinic with evening hours) given the need to work long hours when work is available:

When I worked in Florida, I got big spots that itched ... But I didn't go to the doctor or anything, because during the season, you know, you want to be earning money. You have to take advantage of the chance to earn money while the opportunity is there.

Attitudes and beliefs about chemicals. All participants were asked to discuss how they know when the crops they work with have been sprayed with chemicals. Common responses included the following symptoms of exposure: itching, rashes, vomiting, headaches, swelling, dizziness. Participants agreed that there are many signs of agrichemical usage in the fields.

Sometimes you can tell by the smell. You can detect that. Some spraying leaves some white stuff, like a white liquid on the branches or tree trunks. Sometimes it looks sprayed and a dull white. You can detect if it's sprayed. If not, it's simple: you find animals or plagues [on the plants].

'When I worked in Florida, I got big spots that itched ... But I didn't go to the doctor or anything, because during the season, you know, you want to be earning money. You have to take advantage of the chance to earn money while the opportunity is there.'

The farmers don't want people to know that they put pesticides on the fields. They spray at night and then spray water over the crops to try to hide that they have sprayed. That way the people will still work the next day. But it is easy to see that they had sprayed the night before, even after they wash because they use a lot of chemical. People have headaches, vomit, and bloody noses because of the chemicals.

Participants also shared several stories involving themselves, relatives, and friends who had become sick because of pesticide exposure.

Examples include

I have a brother-in-law that was working spraying poison and he did not wear a mask, no protection, and he was almost poisoned. He got home, he was dizzy and said he didn't even know how he got home, he couldn't even see anymore ... He was very sick, and to this date he is still fragile.

About 3 or 4 years ago, near here, they poisoned a big field. They put on poison and then 3 or 4 days later, the water came and the insecticides vaporized into the air. People breathed it in and got very sick with headaches, and some had stomachaches and others had a rash. They had to send three ambulances.

Participants expressed several concerns about pesticide exposure. Their concerns, however, appeared to be related more to the immediate effects of exposure (such as the symptoms described previously) than long-term effects such as cancer. Several people stated that pesticide exposure is more of a problem for children "because their bodies are smaller," and many others expressed concern about exposure of pregnant women. Stories of babies born dead or without brains because of chemical exposure were recounted in many of the groups.

There was a strong sense of fatalism and powerlessness among the participants in regard to reducing their pesticide exposure. Although they expressed concerns about the health effects of pesticides, it was the belief of many participants that there was no recourse for reducing exposure, given their dependence upon the work. As one man stated, "If I refuse to go into the field, there are many others who would be happy to do it so their families could eat." Similar comments were made by other participants

I worked in other places. If they sprayed and we asked for the special clothes, they told us that we need to bring the clothes or they would take money out of our paychecks for them. The farmers don't protect us. If you don't get the clothes the poison will accumulate in your body and you will die. If you get the suit, then your check will be \$40 lower and you will not have enough for you and your family to eat.

The important thing is that you just want to work. What's important is making sure you pick everything. When you're out there working, you're not out there thinking about whether or not you are going to get sick. You want to work.

Migrant workers' suggestions. While the barriers to effective cancer control among migrant agricultural workers are substantial, a number of suggestions for improving services to migrants emerged from the focus groups. Many men and women commented that knowing that they have to stay healthy to care for their families provides strong motivation to see a physician. A strong sense that the wife and mother is responsible for the family's health and that the father must remain healthy to support the family economically emerged in the discussions. These cultural values and priorities suggest potential approaches to increase the use of cancer screening services.

The focus group results also suggest that providing screening services in migrant housing camps after working hours might increase the use of screening in this population. A woman who received a Pap test in a mobile examination trailer preferred the trailer to the clinic because the process was less time consuming and more convenient. A desire for evening clinic hours also was expressed by a number of participants. In addition, a strong preference for female clinicians was clearly articulated in all of the women's groups.

Several participants offered some suggestions for cancer and other health education efforts in their community. Several participants requested that information on different kinds of cancer, symptoms, and other related issues be provided to them in Spanish. Others stated that small group sessions (for example, focus groups) were ideal for learning more about the disease. Regarding pesticide exposure, one man made a plea to the other participants in his group about the value of collective action in raising and resolving problems.

We need to be united. We also need to find somebody who will help us. If we don't tell somebody our problems, they will continue ... If you go somewhere and tell someone of your problems maybe they can help you and maybe not, but at least they will now realize that a problem exists. If they hear the story over and over again, they will begin to see just how big a problem it is. Finally, someone will help us.

Discussion

Qualitative research using focus group interviews often yields information that is rich in detail and substance on a specific topic (18). While the results of this research cannot be quantified or generalized beyond the participant sample, many of the findings are compelling and instructive. In a focus group setting, participants respond to each other and react to the comments or opinions of others in the group. Thus, focus group interviews have the potential to elicit information that would not be captured in survey questionnaires or other types of individual interviews. The findings from our focus groups are summarized in the box.

These results deepened our cultural understanding of Hispanic migrant agricultural workers' attitudes and concerns about cancer and indicated the types of information and services needed in the community. In addition, the results provided us with background information and general themes that were useful in the development of a survey instrument to conduct larger scale empirical research in this area.

As a group, the migrant agricultural workers in this study believed that agricultural pesticides are toxic and can cause human health problems (including cancer). They also believed that although they are exposed often to these pesticides through their work, there is little they can do to reduce their exposure. These results suggest that migrant agricultural workers are reluctant to raise issues regarding protective clothing or equipment and other protec-

tions offered by laws such as the Federal Insecticide, Fungicide and Rodenticide Act, because they are afraid of losing their jobs. The sense that they are easily replaceable with someone who will not challenge an employer on safety issues appears to prevent many migrant agricultural workers from asking for protections to which they are entitled by law.

In regard to cancer, an intense fear of the disease coupled with fatalism regarding its treatment and course were found to be pervasive among the migrant workers who participated in the focus groups. Cancer was nearly synonymous with death—an association that likely reflected the experience that migrant workers have had with cancer. Impoverished minority subpopulations in the United States experience the highest rates of cancer mortality (12). These grim statistics were sadly personalized in the stories that the migrant participants shared in their groups.

The degree to which the cancer-related knowledge, attitudes, and practices of the Hispanic migrant agricultural workers differ from those of other population subgroups cannot be ascertained from this study. For example, a lack of understanding about the specific purpose of the Pap test is common in all populations, not just Hispanic migrants.

Our findings of widespread fear and fatalistic attitudes toward cancer, however, are similar to what has been reported for other minority and low-income populations (12,19). A previously published study concluded that misconceptions about cancer are more prevalent among Latinos than whites, controlling for several sociodemographic characteristics (20). Compared with whites, Latinos were significantly more likely to agree with several myths regarding cancer etiology and to believe that having cancer is like getting a death sentence, that cancer is God's punishment, and that there is very little one can do to prevent getting cancer. The authors of this study concluded that Latinos' attitudes towards cancer generally fit a cultural concept of *fatalismo*. Some likely results of this attitude are delays in seeking medical attention for cancer symptoms and higher rates of advanced disease at diagnosis, outcomes that have been documented for both men and women of Hispanic descent (21–23).

The results of this qualitative study suggest that basic education regarding cancer is needed in the migrant farm worker population. Perceptions of cancer as a single disease that progressively eats away at the entire body or results in severe disfigurement or multiple amputations need to be challenged and changed before site-specific cancer prevention and early detection efforts will be fully understood and accepted. It will be particularly

Summary of Research Findings from Hispanic Migrant Farm Workers Focus Group Sessions, Wisconsin, 1992

Migrants' Beliefs:

Pesticides

- Can cause health problems
- Concern about acute effects of exposure
- They are powerless to reduce their exposure

Cancer etiology

- Smoking a major cause of cancer
- So are injuries, bruises, neglect of wounds

Cancer treatment

- Few people survive cancer
- Treatment involves pain, disfigurement, and amputation

Cancer Control Barriers:

Lack of knowledge

- Don't know about prevention, screening and symptoms
- Little information in Spanish for low literacy population

Cultural

- Embarrassment and shame associated with physical examinations
- Women prefer female providers
- Little emphasis on preventive health care
- Language

Socioeconomic

- Cost of health services and screening
- Time constraints of long work days
- Transportation

difficult to overcome the fatalistic attitudes that are prevalent in this community until people witness more of their friends and family members surviving cancer. The use of "role models" (that is, persons from the target community who have a positive story to share) may help to counteract the fatalistic attitudes that prevail (24). In addition, methods of educating and reaching people that do not solely rely on printed material need to be explored.

The focus group results yielded information on a number of additional barriers to the early detection of cancer for Hispanic migrant agricultural workers. These barriers are both cultural (for example, *machismo*, including the attitude that it is a sign of weakness to need medical attention; embarrassment and *vergüenza* associated with physical examinations; women's discomfort with male clinicians) and socioeconomic (for example, the cost of service; financial pressure to work; time constraints associated with

long working days; lack of transportation). Efforts to improve cancer screening as well as other preventive health services in the Hispanic migrant agricultural worker population must acknowledge these barriers and address as many of them as possible to be successful.

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